AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM
NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 JULY 2012

Title:	**COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Bob Hibberd, Head of Governance

Purpose:	To inform the Board of Directors of the Governance and assurance processes and outcomes regarding compliance with the 16 Care Quality Commission Essential Standards of Quality and Safety, NHSLA Risk Management Standards and NICE guidance status.
Confidentiality Level & Reason:	None
Annual Plan Ref:	Affects all strategic aims.
Key Issues Summary:	• A robust quarterly assurance process is in place for the core CQC essential standards and NHSLA Risk Management Standards compliance monitoring. • Progress of compliance against CQC and NHSLA Risk Management Standards has been judged to be satisfactory. • Evidence for Essential Standards has been judged to be compliant • An action plan is being monitored against identified gaps
Recommendations:	The Board of Directors is asked to receive the report on compliance with CQC Essential Standards, NHSLA Risk Management Standards and NICE guidance.

Signed:	**Date:** 26 July 2012

UNIVERSITY HOSPITALS BIRMINGHAM
NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 JULY 2012

COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY THE DIRECTOR OF CORPORATE AFFAIRS

1. **Purpose**

This paper presents an overview of compliance against the Trust's overall governance arrangements; Governance is leading several streams of work to strengthen the approach to assurance and the processes that support this. This includes:

- How assurance is provided to the Board
- Improving the process for managing risk registers and how they link to the Board Assurance Framework
- Using regulatory standards and accreditation as a means to improve quality, safety, and the management of risk

As a tool to support this, the Trust uses Allocate Software's online product, HealthAssure. HealthAssure is a risk, governance and assurance tool that has been developed to provide a framework to support managing regulatory regimes, standards, and risks. It gives a near real-time concise view of the Trust's position against these requirements and will be used as part of the Trust's system for providing assurance to the Board.

This paper will be developed over the year 2012/13 and will encompass reporting on Terms of Authorisation, Policy Compliance and the Information Governance Tool Kit. In addition any exceptions to any other regulatory compliance will be reported.

2. **Internal Assurance Process**

Due to the significant overlap of the CQC core essential standards with the NHSLA Risk Management Standards, compliance against these standards is monitored in conjunction by the Governance and Corporate Affairs Team. All CQC core standards and NHSLA risk management criteria are assigned to individual manager leads who are responsible for reporting to the Governance/Corporate Affairs Team any concerns regarding compliance.

For the CQC essential standards, the leads review position statements, identify any potential non-compliance or gaps in assurance; review and update commentary and evidence to demonstrate how the Trust meets the standards. Where gaps in assurance have been identified, action plans are

agreed with the Governance Team. Any action plans and evidence in support of the compliance are saved in the format of CQC Provider Compliance Assessments in a designated folder which is then linked to HealthAssure.

For the NHSLA criteria the leads complete the NHSLA proforma which maps the requirements for each criterion against the relevant policies and procedures. Where gaps in assurance have been identified these are discussed with the Corporate Affairs Team and action plans put in place. Action plans and evidence to support compliance (e.g. reports, minutes, etc) are saved in a designated NHSLA folder which is then linked to Health Assure.

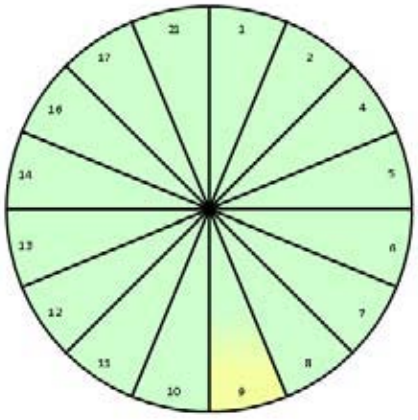
Each quarter, compliance with the CQC core essential standards and NHSLA risk management standards is signed off at Executive Director level.

The full detail of how the Trust monitors compliance with the CQC essential standards and NHSLA risk management standards is set out in the 'Procedure for Monitoring and Assuring Compliance against the Care Quality Commission (CQC) Essential Standards Compliance Monitoring' and the 'NHSLA Compliance Monitoring Procedure' respectively.

3. Compliance status

3.1 CQC Essential Standards

CQC Registration Outcomes

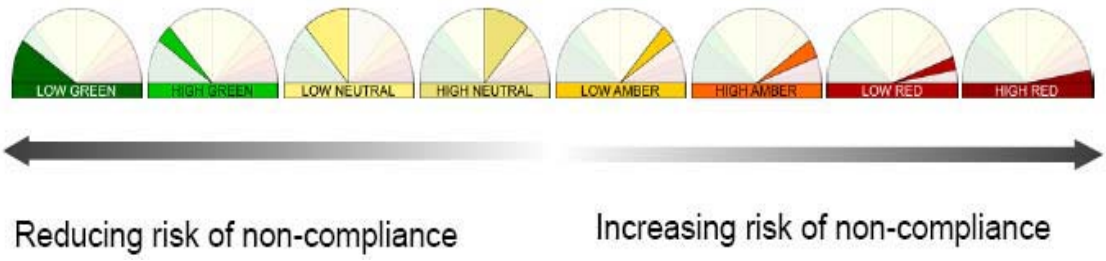


Executive Directors have confirmed compliance with all standards. However for Outcome 9 'medicines management', the Medical Director has taken into consideration that there have been leadership issues in Pharmacy and there is currently insufficient assurance of the robustness of certain processes. An interim Director is undertaking a review of Pharmacy processes, implementing assurance mechanisms where necessary, and will report to the Divisional Director and Medical Director if any failings are identified that impact on compliance against the CQC standard or any other regulatory or statutory requirements. This standard is therefore rated green/amber.

Quality and Risk Profile (QRP) Review

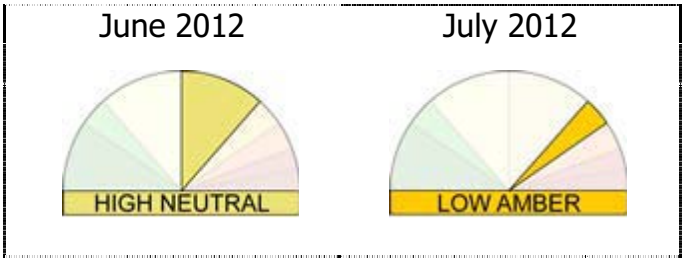
No QRP was published in May 2012. There were no 'amber' or 'red' risk estimates for any Outcomes on the April and June 2012 QRPs.

Key to dials on QRP:



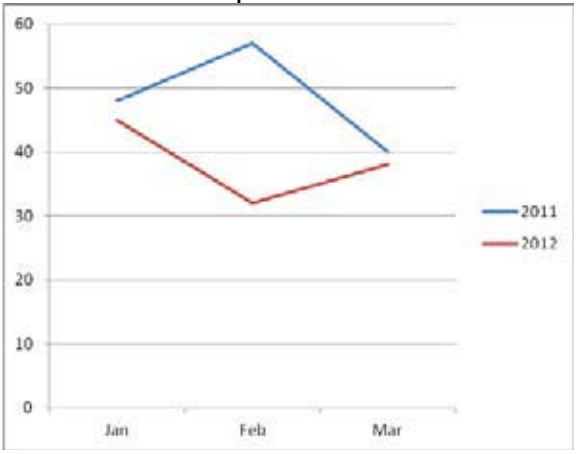
The July 2012 QRP scored 'low amber' for Outcome 6, 'co-operating with other providers' due to negative scores on data items for the Department of Health, 'Delayed Transfers of Care'.

Outcome 6 dial on QRP

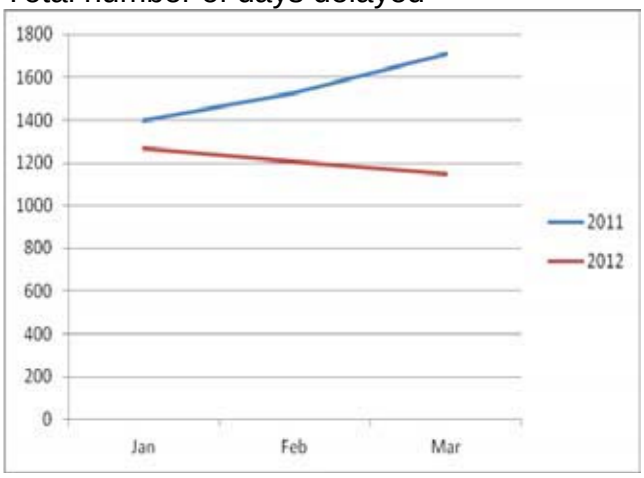


The data items causing increased risk of non-compliance are set out in detail at Annex A, but relate to delayed transfers of care during the period 1 January 2012 to 31 March 2012, where delay is ether attributable to social care, or attributable to NHS and social care. The Director of Partnerships has reviewed the data items. A comparison of delayed transfers of care for the equivalent quarter of 2011, using monthly figures from the UNIFY reports, the same data that the CQC use, is set out below:

Total number of patients whose transfer is delayed



Total number of days delayed



As can be seen, all show an improvement on the same period last year.

As the Board is aware, in terms of the partnership working, since last year a number of mechanisms have been put in place to address the system issues, and to drive improvement. These include weekly discharge meetings between UHB and the Local Authority to discuss delays and a city wide senior level group that involves the Community Trust, the commissioners and the Local Authority. As a result of each of these meetings, UHB has introduced a number of service changes.

3.2 NHSLA Risk Management Standards

The Executive Directors' sign-off for quarter 1 of 2012/13 has been successfully completed. All Executive Directors have confirmed that they are satisfied with the progress made against the NHSLA Risk Management Standards.

All NHSLA criteria have been RAG rated as follows:

- Green - fully compliant;
- Green/amber - assessed to be fully compliant in February 2013. This means the NHSLA pro-forma has been completed and the correct evidence, as referenced in the monitoring matrix of the respective policy or procedure, has been saved to date;
- Amber/red - gaps in assurance have been identified due to incomplete NHSLA proformas and/or insufficient evidence in the designated NHSLA folder.

To date, one criterion (Supervision of medical staff in training) has been rated 'green' as the Trust has received GMC approval for the delivery of training and has been found to 'demonstrate good practice in areas of supervision of trainees and patient safety'. 30 criteria have been rated green/amber and 19 amber/red.

All amber/red criteria have been incorporated into an NHSLA action plan where they are regularly monitored (see Annex B). The Performance and Governance Manager (currently working with the Senior Manager Corporate Affairs) meets the relevant NHSLA leads in regular intervals to review the progress against the action plan; reports to the Director of Corporate Affairs on a monthly basis to update on progress, and escalates to Executive Directors where appropriate.

3.3 Overall compliance with all NICE Guidance

Overall compliance with all NICE Guidance published is shown in tables 1 and 2 below.

Table 1: The percentage of overall compliance with published NICE Guidance applicable to the Trust

Compliance Status	% of all guidance applicable to the Trust
Non Compliant	2%
Awaiting response	11%
Working towards compliance	6%
Under review	5%
Compliant	76%

Table 2: Figures of overall compliance with published NICE Guidance

Guidance Type	Compliance Status						
	Total published	Terminated/ Not applicable	Compliant	Working towards compliance	Under review	Await Response	Not Compliant
Clinical Guidance	129	40	53	16	8	8	4
Technical Appraisals	190	41	119	3	5	20	2
Interventional Procedure Guidance	367	244	106	2	7	8	0
Public Health	36	25	6	0	1	3	1
Medical Technology	9	1	5	0	0	3	0
Diagnostic Guidance	3	1	2	0	0	0	0
Cancer Services	9	0	7	1	0	1	0
Totals	**743**	**352**	**298**	**22**	**21**	**43**	**7**

Details of the seven items where the Trust is not compliant are set out in Annex C.

3.4 Compliance with all NICE Guidance published in Quarter One 1st April – 30th June 2012.

Compliance Status	%
Compliant	5%
Working towards compliance/Under Review	16%
Awaiting response	79%
Not Compliant	0%
Total percentage	**100%**

15 pieces of Guidance are awaiting response (79%) and within timescales for responding, as follows:

- 9 pieces of Guidance are currently with the NICE Sub Group for confirmation of Guidance Lead as per the NICE Procedure;
- For 5 pieces of Guidance, the Lead has had one reminder to respond to the request for compliance status as per NICE Procedure;
- For 1 pieces of Guidance no response has been received and a reminder has been sent. This will be escalated to the Division A Clinical Quality Group on 23rd July 2012 and the Divisional Management Team will be asked to obtain a response.

3.5 NICE Guidance - NHS Litigation Authority dataset

20 pieces of NICE Guidance are listed within the Risk Management Standard 2.8 Best Practice NICE. NHSLA could identify any 2 of the 20 to review during their inspection in February 2013.

Status:

- 4 pieces of guidance are awaiting compliance response and meetings have been arranged with the Clinical Governance Facilitator and NICE Guidance Lead to obtain compliance status and review the associated evidence. These meeting will take place by end of August 2012;
- 1 piece of guidance related to VTE is under review by both the Emergency Department and the Clinical Decision Unit;
- 8 pieces of guidance are compliant;
- 7 pieces of guidance are classified as working towards compliance, as shown in Annex D.

4 Recommendation

The Board of Directors is asked to receive this report regarding compliance with the 16 Care Quality Commission 'core' Essential Standards of Quality and Safety, NHSLA Standards and NICE guidance.

David Burbridge
Director of Corporate Affairs
26 July 2012

Annex A – Data items from CQC QRP

	Item Datasource	Period Start	Period End	Comparison
The ratio of the number of patients whose transfer of care is delayed to the average daily number of occupied beds open overnight in the quarter, where the delay is attributable to Social Care -	Department of Health, Delayed Transfers of Care	01/01/12	31/03/12	Much worse than expected
The ratio of the number of patients whose transfer of care is delayed to the average daily number of occupied beds open overnight in the quarter, where the delay is attributable to NHS and Social Care -	Department of Health, Delayed Transfers of Care	01/01/12	31/03/12	Tending towards worse than expected
The ratio of the total number of days delayed to the total number of occupied beds over the quarter, where the delay is attributable to Social Care -	Department of Health, Delayed Transfers of Care	01/01/12	31/03/12	Much worse than expected
The ratio of the total number of days delayed to the total number of occupied beds over the quarter, where the delay is attributable to both the NHS and Social Care -	Department of Health, Delayed Transfers of Care	01/01/12	31/03/12	Much worse than expected

ANNEX B

Action Plan for NHSLA
Reflecting Executive Director Sign-Off (quarter 1 2012/13)

Standard 1 - Governance

Governance	Requirements	RAG Rating	Agreed Actions
High Level Risk Committee(s) – criterion 1	a) duties b) who the members are, including nominated deputies where appropriate c) how often members must attend d) requirements for a quorum e) how often meetings take place f) reporting arrangements into the high level risk committee(s) g) reporting arrangements into the board from the high level risk committee(s) h) how the organisation monitors compliance with all of the above.	Red/Amber	• Review and amend current TORs to identify reporting arrangements (NHSLA Recommendation) • Continue to populate action plan in line with the control document
Health Records Management – criterion 7	a) duties b) legal obligations that apply to records c) how a new record is created d) how health records are tracked when in current use e) how health records are retrieved from storage f) process for retention, disposal and destruction of records g) how the organisation monitors compliance with all of the above.	Red/Amber	• Complete tabular Monitoring Matrix for the procedural document • Continue audit of the tracking of casenotes • Commence reporting into the Information Governance Committee • Continue to populate action plan in line with the control document

Standard 3 – Competent and Capable Workforce

Governance	Requirements	RAG Rating	Agreed Actions
Local Induction of Temporary Staff - criterion 3	a) duties b) minimum content of local induction c) timescales for completion of local induction d) how the organisation records that all temporary staff complete local induction e) how the organisation follows up those who do not complete local induction f) how the organisation monitors compliance with all of the above.	Red/Amber	• Continue to work on evidencing Medical Induction and assurance for local induction from agency workers • Continue to populate action plan in line with the control document

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Moving & Handling Training - criterion 7	a) duties b) how the organisation records that all permanent staff complete moving and handling training, in line with the training needs analysis c) how the organisation follows up those who do not complete moving and handling training d) action to be taken in the event of persistent non-attendance e) how the organisation monitors compliance with all of the above.	Red/Amber	• Compliance continues to be low due to lack of courses for staff to book on. Agreed to reconsider who actually requires training and whether e-learning can be introduced.
Supporting staff involved in an Incident, Complaint or Claim – criterion 9	a) duties b) immediate support offered to staff (internally and, if necessary, externally) c) ongoing support offered to staff (internally and, if necessary, externally) d) advice available to staff (internally and, if necessary, externally) in the event of their being called as a witness e) action for managers or individuals to take if the staff member is experiencing difficulties associated with the event f) how the organisation monitors compliance with all of the above.	Red/Amber	• Difficulty in quantifying exactly what evidence is required as informal processes will not generate evidence. Query with assessor on the 26/07 • Continue to populate action plan in line with the control document
Stress – criterion 10	a) Duties b) how staff can access information on the management of work-related stress c) how workplace stressors are identified d) how the organisation carries out risk assessments for the prevention and management of work-related stress e) how the organisation monitors compliance with all of the above.	Red/Amber	• The evidence folder needs to be populated in line with evidence identified through the Monitoring Matrix in the Controlled Document

Standard 4 – Safe Environment

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Governance	Requirements	RAG Rating	Agreed Actions
Secure Environment –criterion 1	a) duties b) how the organisation risk assesses the physical security of premises and assets c) how action plans are developed as a result of risk assessments d) how action plans are followed up e) how the organisation monitors compliance with all of the above.	Red/Amber	• The evidence folder needs to be populated in line with evidence identified through the Monitoring Matrix in the Controlled Document. The lead had followed this process for the 2011/12 evidence folder.
Violence & Aggression – criterion 2	a) duties b) how the organisation carries out risk assessments for the prevention and management of violence and aggression c)timescales for review of risk assessments d)how action plans are developed as a result of risk assessments e) how action plans are followed up f) arrangements for making sure lone workers are safe g) how the organisation trains staff in line with the TNA h) how the organisation monitors compliance with all of the above	Red/Amber	• The evidence folder needs to be populated in line with evidence identified through the Monitoring Matrix in the Controlled Document. The lead had followed this process for the 2011/12 evidence folder.
Slips, Trips & Falls (Staff & others) - criterion 3	a) duties b) how the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height) c) how the organisation trains staff, in line with the training needs analysis d) how the organisation raises awareness about preventing and reducing the number of slips, trips and falls involving staff and others e) how the organisation monitors compliance with all of the above.	Red/Amber	• The evidence folder needs to be populated in line with evidence identified through the Monitoring Matrix in the Controlled Document.
Moving & Handling – criterion 5	a) duties b) techniques to be used in the moving and handling of patients and objects, including the use of appropriate equipment c) arrangements for access to appropriate specialist advice d) how the organisation risk assesses the moving and handling of patients and objects e) how action plans are developed as a result of risk assessments	Red/Amber	• The organisation is advised to revisit the issue of their spot check review system ensuring that it is adequate (NHSLA Recommendation). • Back Care and Ergonomics team are currently having difficulty with carrying out the quarterly quota of audits for NHSLA evidence (NHSLA Lead). • Manual Handling Action Plan produced as a result

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	f) how action plans are followed up g) how the organisation monitors compliance with all of the above.		of a meeting on the 20/06.
The Deteriorating Patient – criterion 8	a) requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement b) use of an early warning system within the organisation to recognise patients at risk of deterioration c) actions to be taken to minimise or prevent further deterioration in patients d) do not attempt resuscitation orders (DNAR) e) how the organisation documents that resuscitation equipment is checked, stocked and fit for use f) how the organisation monitors compliance with all of the above.	Red/Amber	• Update and review the Monitoring Matrix. • Ensure that the Resuscitation is included for the two requirements. • Continue to populate action plan in line with the control document.

Standard 5 – Acute, Community and Non NHS Providers

Governance	Requirements	RAG Rating	Agreed Actions
Consent Training - criterion 3	a) how the organisation trains clinical staff on the consent process, in line with the training needs analysis b) how the organisation identifies clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure c) how the organisation provides procedure-specific training on consent for clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure d) how the organisation follows up where an individual has obtained consent without the authorisation to do so e) how the organisation notifies the GMC via the required form, of any individual who has obtained consent without the authorisation to do so f) how the organisation monitors compliance with all of the above.	Red/Amber	• Emails reminding individuals of the need to return delegated consent forms have been distributed and have been receiving a response. • Continue to populate action plan in line with the control document

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Screening procedures – criterion 6	a) a list of the screening procedures carried out on the organisation's own patients b) how the organisation risk assesses screening procedures c) how the screening procedure is requested d) how the clinician treating the patient is informed of the result, including timescales e) how the patient is informed of the result including timescales f) how the patient is follow up or referred including timescales g) how minimum requirements c) to f) are recorded h) how the organisation monitors compliance with all the above	Red/Amber	• The Lead is leading a scoping exercise which will produce a document in time for the NHSLA assessors pre visit on the 26th July
Diagnostic Testing Procedures – criterion 7	a) a list of the diagnostic tests carried out on the organisation's own patients b) how the organisation risk assesses diagnostic testing procedures For each of the diagnostic tests listed, your documented process must include: c) how the diagnostic test is requested d) how the clinician treating the patient is informed of the result, including timescales e) how the patient is informed of the result, including timescales f) actions taken by Clinician including timescales g) how minimum requirements c) to f) are recorded h) how the organisation monitors compliance with all of the above.	Red/Amber	• The Lead has carried out a scoping exercise to identify all diagnostic tests and screening programmes carried out at the Trust. These then need to be risk assessed as only for 'high risk' tests and diagnostic testing and screening procedures will be assessed. Clarification will be sought from the assessor as to how this risk assessment is to be carried out.
Venous Thromnoembolism – criterion 9	a) how patients are assessed for their risk of developing venous thromboembolism (VTE), including timescales b) prophylactic treatment regime for high risk patients c) procedure to be followed if VTE is suspected d) management of the patient once a positive diagnosis has been made e) management of the patient once a positive diagnosis has been made d) management of the patient once a positive diagnosis has been made e) how the organisation trains staff, in line with TNA f) how the organisation monitors compliance with all of the above	Red/Amber	• Meeting on the 16/07 to identify sources of evidence. • Informatics have also been contacted as have the Clinical Quality Monitoring department

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Medicines Management – criterion 10	a) how medicines are prescribed b) how the organisation makes sure that all prescription charts are accurate c) how medication errors are reported d) how the organisation learns from medication errors e) how a patient's medicines are managed on handover between care settings f) how the organisation trains staff, in line with the training needs analysis g) how the organisation monitors compliance with all of the above.	Red/Amber	• Meeting with the NHSLA assessor on the 26th July to discuss and review the requirements of the criteria

ANNEX C

NICE Guidance categorised as Non Compliant

There are currently 7 pieces of Guidance categorised as non compliant. Non compliance is classified as a group of Clinicians currently not working towards compliance for valid clinical reasons. This categorisation will be reviewed by the Clinical Quality Monitoring Group at their meeting to be held on Thursday 9th August 2012. Any decision made by the Clinical Quality Monitoring Group approving non compliance will be referred to the Chief Executive's Advisory Group for ratification.

NICE ID and Title	**Lead, Specialty**	**Current status**	**% of recommendations non compliant**
CG100 Alcohol-use disorders: physical complications	Robin Snead, Deputy Divisional Director for Division C and Chair of the Alcohol Liaison Group	Non compliant with 1 of 37 recommendations but compliant with all 5 key priority recommendations. The Trust does not currently provide symptom triggered alcohol detoxification as this requires specialist staff. Clinical guidance for the management of patients who do present to the Hospital with alcohol related illnesses and injuries are in draft and will be ratified at a future Clinical Guidelines Group when finalised. Compliance is being reviewed by a Clinical Governance Facilitator and Clinical Nurse Specialist in Addiction Psychiatry and RAID Service Lead at a meeting in August 2012. Patient outcomes as listed within the NICE Alcohol Quality Standard will also be reviewed.	2%

NICE ID and Title	Lead, Specialty	Current status	% of recommendations non compliant
CG080 Early and locally advanced breast cancer	Alan Jewkes, Consultant Breast Surgeon	Non compliant with 1 of 80 recommendations. The non compliant recommendation is also a key priority for implementation. The Trust does not currently provide annual mammography for breast follow up for 5 years. The Breast Service does provide 2-yearly follow up and there is an annual clinical follow up. At the Divisional Clinical Quality Group meeting on 23rd July it will be recommended this Guidance category changes from non compliant to working towards compliance. A business case is being written for resource for a screening mobile and staffing to enable capacity of an additional 15 appointments per week. The business case should be completed by the end of Quarter 2 30th September 2012.	1%
CG079 Rheumatoid arthritis: the management of rheumatoid arthritis in adults	Dr Paresh Jobanputra, Consultant Rheumatologist	Non compliant with 1 of 55 recommendations relating to the use of combination disease modifying drug therapy in patients with newly diagnosed rheumatoid arthritis. This is also a key priority for implementation. The Rheumatology Consultants have requested that the use of combination disease modifying drug therapy in patients with newly diagnosed rheumatoid arthritis is considered on a patient by patient basis and is not considered in all cases and have provided research evidence which contradicts the NICE guidance. This evidence for this approach will be discussed at the Clinical Quality Monitoring Group.	2%
CG032 Nutrition support in adults	Jane Fletcher, Clinical Nurse Specialist - Nutrition	Non compliant with 1 of 87 recommendations but compliant with all 5 key priority recommendations. Non compliance related to patients on nutritional support having their manganese levels checked every 3-6 months. The Nutrition Steering Group meeting have supported this non	1%

NICE ID and Title	Lead, Specialty	Current status	% of recommendations non compliant
		compliance. The Nutrition Support Nurses will monitor manganese if they have a clinically valid reason for doing so but this is not routine practice. The National Recognised Centre at St Marks also does not measure manganese levels due to the minimal impact on outcome. The Health Informatics Analytics & Intelligence Manager is exploring current data for those patients who do have their manganese levels checked. To be discussed at CQMG in August.	
TA230 Myocardial infarction (persistent ST-segment elevation) - bivalirudin	John Townend, Clinical Service Lead and Consultant Cardiologist	The use of bivalirudin has been considered by the Cardiology Service. An audit undertaken to compare results with Bivaliridin against the current practice shows current practice for STEMI is favourable. The Cardiology networks at other Acute Trusts believe that there are better drugs available. Non compliance with this technical appraisal remains on the risk register. The consequence is minor, likelihood likely with risk rating moderate and residual risk rating low (with tolerance). An ongoing audit has been requested to review bleeding rates. Approved at CQMG	100%

NICE ID and Title	Lead, Specialty	Current status	% of recommendations non compliant
TA114 Drug misuse - methadone and buprenorphine	Abbie Gogarty, Drug and Alcohol Liaison Nurse	Methadone and buprenorphine (oral formulations), using flexible dosing regimens, are recommended as options for maintenance therapy in the management of opioid dependence. The Trust follows West Mercia guidance which differs from the NICE recommendation. Methadone only is recommended as buprenorphine needs to be initiated under the close supervision of a specialist substance misuse practitioner. The Drug and Alcohol Team at the Trust believe there is a significant risk of precipitated opioid withdrawal if Buprenorphine is administered inappropriately. In addition, many patients who present will require opiate based analgesia, which would be inappropriate if patients were taking Buprenorphine. The PAN Birmingham Drug and Alcohol Team have indicated support for this non compliance. To be discussed at CQMG in August 2012	100%
PH034 Increasing the uptake of HIV testing among men who have sex with men	Sharon Lewis, Head of Sexual Health Services	Non compliant with 1 of 7 recommendations. The Trust does not currently provide rapid point of care testing in an outreach setting. The relevance of this recommendation is being discussed further on the 21st August with the Lead Consultant for Sexual Health & HIV Medicine and non compliance may change to not applicable.	14%

ANNEX D

NICE Guidance - Working towards compliance**:**

1. CG29 Pressure Ulcer Management - The trust does not routinely photograph pressure ulcers. Pressure ulcers are however measured for width, length and depth as NICE recommend but this is not always evidenced by photography as the guidance recommends. An action plan is in place to photograph pressure ulcers at grade 3 and 4. A detailed action plan covering these issues has been requested and this will be discussed at the next Pressure Ulcer Action Group in August 2012.

2. CG50 Acutely Ill Patients – An action plan is in place to achieve compliance. This guidance is to be monitored through the Patient Safety Group and will be discussed at their next meeting in August 2012.

3. CG76 Medicines adherence – Patient experience with medicines management forms the basis of the evidence for compliance against this guidance. A pilot patient satisfaction survey is being managed by the Patient Experience team with results reported to the Care Quality Group in December 2012.

4. CG85 Glaucoma – A business case has been approved by the Chief Executive Advisory Group for the implementation of a new system to aid electronic reporting. Once this software has been purchased an implemented compliance will be achieved. The expected date for compliance is July 2013.

5. CG97 Lower Urinary Tract Symptoms – An action plan is in place to achieve compliance. This guidance is monitored through the Continence Action Group and will be discussed at their next meeting in September 2012.

6. CG103 Delirium – An action plan is in place to achieve compliance. This action plan is monitored through the Care Quality Group.

7. CG104 Metastatic Malignant Disease of unknown primary origin - The Acute Oncology Working Group is due to start working towards compliance with this guidance in August 2012 with a proposed deadline for compliance is the end September 2012.